FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026294

Facility Name: ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME

Address: 5448 NORTH BROADWAY (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: 773-334-2224 **Fax #** 773-334-0360

IDPA ID Number: 36-3121954

Date of Initial License for Current Owners: 5/8/1981

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) HOWARD WENGROW

(Title) OWNER

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) RICHARD S. SGARLATA

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,568	1
2		Skilled Pediatric (SNF/PED)			2
3	96	Intermediate (ICF)	96	35,136	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,704	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,719			1,719	8
9	SNF/PED					9
10	ICF	46,037	34		46,071	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,756	34		47,790	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.68%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/1981

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/1981 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [NO] If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN N # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	199,732	35,694	11,594	247,020		247,020	19,277	266,297			1
2	Food Purchase		197,208		197,208	(9,516)	187,692	(1)	187,691			2
3	Housekeeping	136,940	54,342		191,282		191,282		191,282			3
4	Laundry	55,280	22,851		78,131		78,131		78,131			4
5	Heat and Other Utilities			90,411	90,411		90,411	2,195	92,606			5
6	Maintenance	114,907	36,731	81,325	232,963		232,963	(5,257)	227,706			6
7	Other (specify):*							2,661	2,661			7
8	**TOTAL General Services**	506,859	346,826	183,330	1,037,015	(9,516)	1,027,499	18,875	1,046,374			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	1,247,734	27,060	4,908	1,279,702		1,279,702	(980)	1,278,722			10
10a	Therapy	16,915		21,875	38,790		38,790		38,790			10a
11	Activities	77,650	6,650	2,204	86,504		86,504		86,504			11
12	Social Services	104,863		3,566	108,429		108,429		108,429			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,447,162	33,710	34,353	1,515,225		1,515,225	(980)	1,514,245			16
	C. General Administration											
17	Administrative	52,398		273,200	325,598		325,598	(141,069)	184,529			17
18	Directors Fees											18
19	Professional Services			21,017	21,017		21,017	1,591	22,608			19
20	Dues, Fees, Subscriptions & Promotions			28,283	28,283		28,283	(7,397)	20,886			20
21	Clerical & General Office Expenses	18,953	39,641	38,237	96,831		96,831	17,585	114,416			21
22	Employee Benefits & Payroll Taxes			278,900	278,900	9,516	288,416		288,416			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,673	1,673		1,673	451	2,124			24
25	Other Admin. Staff Transportation			397	397		397	2,222	2,619			25
26	Insurance-Prop.Liab.Malpractice			44,591	44,591		44,591	2,130	46,721			26
27	Other (specify):*							11,902	11,902			27
28	**TOTAL General Administration**	71,351	39,641	686,298	797,290	9,516	806,806	(112,585)	694,221			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,025,372	420,177	903,981	3,349,530		3,349,530	(94,690)	3,254,840			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME
0026294
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	9,516	
2	FOOD		9,516

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOM#0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			32,123	32,123		32,123	13,843	45,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,897	2,897		2,897	(2,897)				32
33	Real Estate Taxes			81,979	81,979		81,979		81,979			33
34	Rent-Facility & Grounds			492,000	492,000		492,000	(480,424)	11,576			34
35	Rent-Equipment & Vehicles			4,961	4,961		4,961	5,426	10,387			35
36	Other (specify):*											36
37	**TOTAL Ownership**			613,960	613,960		613,960	(464,052)	149,908			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,056	79,056		79,056		79,056			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			79,056	79,056		79,056		79,056			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,025,372	420,177	1,596,997	4,042,546		4,042,546	(558,742)	3,483,804			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,032	30		9
10	Interest and Other Investment Income	(2,897)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,955)	20		18
19	Entertainment				19
20	Contributions	(606)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,207)	21		24
25	Fund Raising, Advertising and Promotional	(317)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,067)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,781)	20		28
29	Other-Attach Schedule	(11,536)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (32,335)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(526,407)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (526,407)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (558,742)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME

ID# 0026294

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Real Estate Tax Late Fee	(141)	20	2
3	Repairs & Maintenance Capitalized	(11,395)	6	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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14				14
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82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(11,536)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HO! # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				19,277								19,277	1
2	Food Purchase	(1)											(1)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,195									2,195	5
6	Maintenance	(11,395)		876	5,262								(5,257)	6
7	Other (specify):*				2,661								2,661	7
8	**TOTAL General Services**	(11,396)		3,071	27,200								18,875	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(980)									(980)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**			(980)									(980)	16
	C. General Administration													
17	Administrative			(250,846)	109,777								(141,069)	17
18	Directors Fees													18
19	Professional Services			1,591									1,591	19
20	Fees, Subscriptions & Promotions	(7,800)		403									(7,397)	20
21	Clerical & General Office Expenses	(19,274)		36,859									17,585	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			451									451	24
25	Other Admin. Staff Transportation			2,222									2,222	25
26	Insurance-Prop.Liab.Malpractice			2,130									2,130	26
27	Other (specify):*			6,616	5,286								11,902	27
28	**TOTAL General Administration**	(27,074)		(200,574)	115,063								(112,585)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(38,470)		(198,483)	142,263								(94,690)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HO! # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	9,032		3,036	1,775								13,843	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,897)											(2,897)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(492,000)	11,576									(480,424)	34
35	Rent-Equipment & Vehicles			5,426									5,426	35
36	Other (specify):*													36
37	**TOTAL Ownership**	6,135	(492,000)	20,038	1,775								(464,052)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(32,335)	(492,000)	(178,445)	144,038								(558,742)	45

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HOWARD WENGROW	50.00%	SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		
JEFF WEBSTER	50.00%	SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT-FACILITY & GROUNDS	$ 492,000	ZIKAINIM PARTNERSHIP		$	$ (492,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 492,000			$	$ * (492,000)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	STAY CARE MANAGEMENT, LTD.	100.00%	$ 2,195	$ 2,195	15
16	V	6	REPAIRS AND MAINT.				876	876	16
17	V	10	REHABILITATION CONS.				(980)	(980)	17
18	V	17	ADMIN. SAL.-NON OWNER				22,354	22,354	18
19	V	19	PROFESSIONAL FEES				1,591	1,591	19
20	V	20	DUES, SUBSCRIPTIONS				403	403	20
21	V	21	CLERICAL & GENERAL				36,859	36,859	21
22	V	24	SEMINARS				451	451	22
23	V	25	ADMIN. STAFF TRAVEL				2,222	2,222	23
24	V	26	INSURANCE				2,130	2,130	24
25	V	27	EMPLOYEE BENEFITS				6,616	6,616	25
26	V	30	DEPRECIATION				3,036	3,036	26
27	V	34	BUILDING RENT				11,576	11,576	27
28	V	35	EQUIPMENT RENTAL				5,426	5,426	28
29	V	17	MANAGEMENT FEES	273,200			0	(273,200)	29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 273,200			$ 94,755	$ * (178,445)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIET. COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.	100.00%	$ 19,277	$ 19,277	15
16	V	6	MAINT. COMP. - NON-OWNER				5,262	5,262	16
17	V	7	EMP. BEN. - S. WEBSTER				1,603	1,603	17
18	V	7	EMP. BEN. - MAINT. NON-OWNER				1,058	1,058	18
19	V	17	ADMIN. BONUS				0		19
20	V	17	ADMIN. COMP - H. WENGROW				85,418	85,418	20
21	V	17	ADMIN. COMP - J. WEBSTER				24,359	24,359	21
22	V	27	EMP. BEN. - H. WENGROW				4,081	4,081	22
23	V	27	EMP. BEN. - J. WEBSTER				1,205	1,205	23
24	V	30	DEPR.- AUTO - MINI VAN				1,775	1,775	24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 144,038	$ * 144,038	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JEFFERY WEBSTER	OWNER	ADMINISTRATIV	50.00%	SEE ATTACHED	6	9.23%	Salary-Staycar	$ 24,359	17-7	1
2	HOWARD WENGROW	OWNER	ADMINISTRATIV	50.00%	SEE ATTACHED	20	30.77%	Salary-Staycare	85,418	17-7	2
3	SARAH WEBSTER	RELATIVE	DIETARY	0.00%	NONE	35	100.00%	Salary-Staycare	19,277	1-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 129,054		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: STAY CARE MANAGEMENT, LTD.
Street Address: 7313 N. WESTERN AVE.
City / State / Zip Code: CHICAGO, IL. 60645
Phone Number: (773) 338-2121
Fax Number: (773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	177,354	5	$ 8,146	$	47,790	$ 2,195	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	177,354	5	3,250		47,790	876	2
3	10	REHABILITATION CONS.	PATIENT DAYS	177,354	5	(3,636)		47,790	(980)	3
4	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	177,354	5	82,960	82,960	47,790	22,354	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	177,354	5	5,905		47,790	1,591	5
6	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	177,354	5	1,497		47,790	403	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	177,354	5	136,787	96,823	47,790	36,859	7
8	24	SEMINARS	PATIENT DAYS	177,354	5	1,675		47,790	451	8
9	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	177,354	5	8,245		47,790	2,222	9
10	26	INSURANCE	PATIENT DAYS	177,354	5	7,905		47,790	2,130	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	177,354	5	24,552		47,790	6,616	11
12	30	DEPRECIATION	PATIENT DAYS	177,354	5	11,266		47,790	3,036	12
13	34	BUILDING RENT	PATIENT DAYS	177,354	5	42,960		47,790	11,576	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	177,354	5	20,136		47,790	5,426	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 351,648	$ 179,783		$ 94,755	25

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: STAY CARE MANAGEMENT, LTD.
Street Address: 7313 N. WESTERN AVE.
City / State / Zip Code: CHICAGO, IL. 60645
Phone Number: (773) 338-2121
Fax Number: (773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	35	1	19,277	19,277	35	19,277	1
2	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	5	26,310	26,310	8	5,262	2
3	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	35	1	1,603		35	1,603	3
4	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	5	5,291		8	1,058	4
5	17	ADMIN. BONUS	AVG. HOURS WORKED	40	1	250				5
6	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	5	277,610	277,610	20	85,418	6
7	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	65	5	263,887	263,887	6	24,359	7
8	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	5	13,264		20	4,081	8
9	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	65	5	13,052		6	1,205	9
10	30	DEPR.- AUTO - MINI VAN	AVG. HOURS WORKED	35	1	1,775		35	1,775	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 622,319	$ 587,084		$ 144,038	25

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN I # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURERS BANK		X	WORKING CAPITAL	VARIOUS	8/28/95					1,320	6
7	TRANS AMERICAN		X	INSURANCE	VARIOUS	VARIOUS		40,781			1,577	7
8	DUE FROM PARTNERSHIP	X		VARIOUS	VARIOUS	VARIOUS		63,310				8
9	TOTAL Facility Related						$	$ 104,091			$ 2,897	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	INTEREST INCOME		X								(2,897)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,897)	14
15	TOTALS (line 9+line14)						$	$ 104,091			$ (0)	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NU # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	85,606	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	82,555	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,051)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	85,030	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	81,979	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	70,800	8
	1996	72,542	9
	1997	81,664	10
	1998	83,113	11
	1999	82,555	12

ACCRUED EXPENSE CALCULATION: 82555 x 1.03 = 85030

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,350 B. General Construction Type: Exterior BRICK Frame FIREPROOF BRICK Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	18,750	1981	$ 87,895	1
2					2
3	TOTALS	18,750		$ 87,895	3

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	144		1964	1930	$ 514,131	$	35	$	$	$ 514,131	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1968	2,650		20			2,650	9
10	Various			1972	5,248		20			5,248	10
11	Various			1974	6,075		20			6,075	11
12	Various			1975	22,572		20			22,572	12
13	Various			1978	24,379		20			24,379	13
14	Various			1979	217,961		20			217,961	14
15	Various			1980	41,050		20			41,050	15
16	Various			1981	9,192		20			9,192	16
17	Various			1985	30,550		20			30,550	17
18	Various			1986	49,476	3,998	20	760	(3,238)	37,066	18
19	Various			1987	32,346	1,025	20	1,578	553	8,017	19
20	Various			1988	11,000	349	20	537	188	2,724	20
21	Various			1989	60,399	1,917	20	2,946	1,029	26,145	21
22	Various			1990	10,050	319	20	490	171	4,314	22
23	Various			1991	38,074	891	20	1,869	978	13,462	23
24											24
25	PAGE 12-1 REP TOTALS				7,635	3,035		247	(2,788)	2,087	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				44,014	148		1,719	1,571	2,368	33
34	PAGE 12B TOTALS				54,058	260		2,708	2,448	8,144	34
35	PAGE 12A TOTALS				359,172	7,649		17,931	10,282	97,470	35
36	TOTAL (lines 4 thru 35)				$ 1,540,032	$ 19,591		$ 30,785	$ 11,194	$ 1,075,605	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1992	34,062	1,387	20	1,677	290	14,416	9
10	Various			1993	15,250	645	20	757	112	5,445	10
11	Various			1994	43,886	1,126	20	2,194	1,068	12,454	11
12	Various			1995	194,671	3,345	20	9,736	6,391	50,960	12
13	SHOWER-38.4 FLOOR			1996	2,100	54	20	105	51	473	13
14	THERMOSTAT			1996	5,945	152	20	297	145	1,337	14
15	SHOWER			1996	4,400	113	20	220	107	1,100	15
16	JAMERSON BAUWENS			1996	20,660	530	20	1,033	503	4,993	16
17	SHOWER			1996	3,218	83	20	161	78	711	17
18	FLOOR CEILINGS, 38.4			1996	1,800	46	20	90	44	413	18
19	SHOWER			1996	2,150	55	20	108	53	522	19
20	PIPING			1996	2,633	68	20	132	64	627	20
21	FIRE ALARM SYSTEM			1996	1,749	45	20	87	42	428	21
22	TOILETS			1996	1,557		20	78	78	156	22
23	WATER SYSTEM			1996	3,621		20	181	181	362	23
24	DECORATING			1996	10,091		20	505	505	1,010	24
25	SHOWERS			1996	637		20	32	32	64	25
26	SUMP PIT & PUMP			1997	1,500		20	75	75	244	26
27	SHOWER FAUCETS			1997	1,045		20	52	52	195	27
28	HOT WATER LINE			1997	735		20	37	37	139	28
29	TUB REPAIRS			1997	859		20	43	43	168	29
30	PIPES & FITTING			1997	1,200		20	60	60	195	30
31	VINYL BASE			1997	573		20	29	29	114	31
32	BOILER/SEWER REPAIRS			1997	1,210		20	61	61	239	32
33	TILE			1997	830		20	42	42	165	33
34	SEWER & PIPING			1997	1,845		20	92	92	368	34
35	SEWER PIPING			1997	945		20	47	47	172	35
36	TOTAL (lines 4 thru 35)				$ 359,172	$ 7,649		$ 17,931	$ 10,282	$ 97,470	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER HEATER			1997	4,777	122	20	239	117	797	9
10	VINYL BASE			1997	573		20	29	29	109	10
11	SEWER REPAIR			1997	1,210		20	61	61	188	11
12	SINK			1997	5,168		20	258	258	946	12
13	TUCKPOINTING			1997	650		20	33	33	102	13
14	GREASE TRAP			1997	855		20	43	43	147	14
15	NURSE CALL SYSTEM			1997	1,875		20	94	94	345	15
16	REMODELING			1997	4,550		20	228	228	836	16
17	DOORS			1997	940		20	47	47	165	17
18	PIPES			1997	750		20	38	38	117	18
19	GREASE TRAP			1997	855		20	43	43	143	19
20	HANDRAILS & BUMPERS			1997	2,195	56	20	110	54	440	20
21	DRAIN PIPING			1997	575		20	29	29	97	21
22	SPRINKLER HEADS			1997	2,158		20	108	108	342	22
23	FIRE RATED DOOR FRAM			1998	790		20	40	40	117	23
24	WALL MOUNT FAN			1998	673		20	34	34	91	24
25	LOCKS ON INTAKE DOOR			1998	750		20	38	38	108	25
26	FIRE PROOFING			1998	975		20	49	49	139	26
27	SEWER REPAIR			1998	7,635		20	382	382	1,051	27
28	SECURITY SYSTEM			1998	545		20	27	27	65	28
29	REPLACEMENT WINDOWS			1998	750		20	38	38	89	29
30	MATLES MAT.			1998	715		20	36	36	102	30
31	TUCKPOINTING			1998	700		20	35	35	105	31
32	HVAC			1998	3,181	82	20	159	77	451	32
33	SECURITY SYSTEM			1998	3,886		20	194	194	420	33
34	PAINTING & WALLPAPER			1998	4,200		20	210	210	473	34
35	ELECTRICAL			1999	2,127		20	106	106	159	35
36	TOTAL (lines 4 thru 35)				$ 54,058	$ 260		$ 2,708	$ 2,448	$ 8,144	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PHONE SYSTEM			1999	537		20	27	27	41	9
10	WALLPAPER			1999	1,951		20	98	98	147	10
11	TILE FLOOR			1999	5,953		20	298	298	447	11
12	FLOOR BASE / WALLS			1999	950		20	48	48	72	12
13	SPRINKLER SYSTEM			1999	768		20	38	38	57	13
14	SPRINKLER SYSTEM			1999	1,107		20	55	55	83	14
15	GREASE TRAP			1999	1,300		20	65	65	98	15
16	AWNING			1999	2,000		20	100	100	150	16
17	SINKS / BATHTUBS			1999	2,344		20	117	117	176	17
18	ALUMICOAT			1999	1,371		20	69	69	104	18
19	WALLS			1999	6,930		20	347	347	521	19
20	WINDOW COVERINGS			1999	588		20	29	29	44	20
21	GLASS DOOR			2000	549		20	9	9	9	21
22	NURSES STATIONS			2000	9,190	148	20	307	159	307	22
23	PAINT-PT ROOMS			2000	5,590		20	23	23	23	23
24	ELEVATOR CAR			2000	719		20	3	3	3	24
25	PUMP & WALL FAN			2000	592		20	30	30	30	25
26	BRICK WORK-DOOR			2000	975		20	41	41	41	26
27	FENCE			2000	600		20	15	15	15	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 44,014	$ 148		$ 1,719	$ 1,571	$ 2,368	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED FROM STAYCARE		1992	1992	4,705	105	20	235	130	2,075	9
10	ALLOCATED FROM STAYCARE		2000	2000	2,930	2,930	20	12	(2,918)	12	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 7,635	$ 3,035		$ 247	$ (2,788)	$ 2,087	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NUR # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 132,671	$ 5,275	$ 13,270	$ 7,995		$ 66,500	37
38	Current Year Purchases	12,654	10,284	1,052	(9,232)		(9,232)	38
39	Fully Depreciated Assets	251,830		850	850		251,830	39
40								40
41	TOTALS	$ 397,155	$ 15,559	$ 15,172	$ (387)		$ 309,098	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	ALLOC - STAYCARE			$ 19,886	$ 1,775	$	$ (1,775)	5	$ 19,886	42
43										43
44										44
45										45
46	TOTALS			$ 19,886	$ 1,775	$	$ (1,775)		$ 19,886	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,044,968	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 36,925	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 45,957	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 9,032	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,404,589	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME
0026294
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
ZIKAINIM	114,640	5,275	11,466	6,191	55,022
STAYCARE	18,031		1,804	1,804	11,478
TOTALS	132,671	5,275	13,270	7,995	66,500
LINE 29: CURRENT YEAR					
ZIKAINIM	12,654	10,284	1,052	(9,232)	(9,232)
STAYCARE					
TOTALS	12,654	10,284	1,052	(9,232)	(9,232)
LINE 30: FULLY DEPRECIATED					
ZIKAINIM	251,830		850	850	251,830
STAYCARE					
TOTALS	251,830		850	850	251,830
TOTALS (Should Tie to Totals on Page 13)					
ZIKAINIM	379,124	15,559	13,368	(2,191)	297,620
STAYCARE	18,031		1,804	1,804	11,478
TOTALS	397,155	15,559	15,172	(387)	309,098

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HO # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions	ALLOCATION FROM STAYCARE			11,576			4
5								5
6								6
7	TOTAL				$ 11,576 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,515 Description: ALLOCATION FROM STAYCARE: $5,426; closed circuit TV lease: $89
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	98 Toyota Avalon	$ 406.00	$ 4,872	17
18					18
19					19
20					20
21	TOTAL		$ 406.00	$ 4,872	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist	N/A	hrs							3
4	Licensed Physical Therapist	N/A	hrs							4
5	Physician Care	N/A	visits							5
6	Dental Care	N/A	visits							6
7	Work Related Program	N/A	hrs							7
8	Habilitation	N/A	hrs							8
9	Pharmacy	N/A	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	N/A	hrs							10
11	Academic Education	N/A	hrs							11
12	Exceptional Care Program	N/A								12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HO # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 189,750	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	949,793		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,166		6
7	Other Prepaid Expenses	625		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,203,334	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	512,072		15
16	Equipment, at Historical Cost	300,595		16
17	Accumulated Depreciation (book methods)	(458,662)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 354,005	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,557,339	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 57,590	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	104,092		29
30	Accrued Salaries Payable	75,341		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,947		31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,030		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,060		35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 332,060	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 332,060	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,225,279	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,557,339	$ #REF!	48

*(See instructions.)

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING H# 0026294 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow		

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax - Non Care Property		

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 904,602	1
2	Restatements (describe):		2
3	**Schedule attached**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 904,602	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	464,677	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(144,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 320,677	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,225,279	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	ZIKAINIM INC. D/B/A/ ALL AMERICA #	0026294	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		904,602
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		904,602
Equity(Deficit) from Page 17 Col 1		1,225,279
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		1,225,279

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURS # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,500,753	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,500,753	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,470	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,470	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,507,223	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,037,015	31
32	Health Care	1,515,225	32
33	General Administration	797,290	33
	B. Capital Expense		
34	Ownership	613,960	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	79,056	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,042,546	40
41	**Income before Income Taxes (line 30 minus line 40)****	464,677	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 464,677	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **ZIKAINIM INC. D/B/A/ ALL AMEI # 0026294** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOM # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,930	2,050	$ 51,445	$ 25.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,556	15,500	275,398	17.77	3
4	Licensed Practical Nurses	21,517	22,917	365,916	15.97	4
5	Nurse Aides & Orderlies	65,865	69,797	545,523	7.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,919	2,015	16,915	8.39	8
9	Activity Director	2,138	2,226	20,615	9.26	9
10	Activity Assistants	8,302	8,954	57,035	6.37	10
11	Social Service Workers	9,006	9,797	104,863	10.70	11
12	Dietician					12
13	Food Service Supervisor	2,113	2,297	26,095	11.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,433	23,963	173,637	7.25	15
16	Dishwashers					16
17	Maintenance Workers	13,384	14,319	114,907	8.02	17
18	Housekeepers	19,172	20,537	136,940	6.67	18
19	Laundry	6,569	7,193	55,280	7.69	19
20	Administrator	1,688	1,800	52,398	29.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,183	2,314	18,953	8.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,188	1,196	9,452	7.90	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	193,963	206,875	$ 2,025,372 *	$ 9.79	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	269	$ 8,594	1-3	35
36	Medical Director	Monthly	1,800	9-3	36
37	Medical Records Consultant	Monthly	3,948	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	960	10-3	39
40	Physical Therapy Consultant	65	3,447	10A-3	40
41	Occupational Therapy Consultant	Monthly	18,428	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,204	11-3	44
45	Social Service Consultant	Monthly	1,714	12-3	45
46	Other(specify)				46
47	PSYCH SOC CONSULTANT	34	1,851	12-3	47
48	KOSHER SUPERVISON	Monthly	3,000	1-3	48
49	TOTAL (lines 35 - 48)	410	$ 45,946		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURS # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Steve Klekamp	Administrator	0%	52,398
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,398

B. Administrative - Other

Description	Amount
Staycare Management	$ 273,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 273,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sachnoff and Weaver	Legal	$ 1,210
Personnel Planners	Unemployment Consultant	906
Frost, Ruttenberg & Rothblatt	Accounting	18,900
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 21,016

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 17,072
Unemployment Compensation Insurance	13,388
FICA Taxes	153,426
Employee Health Insurance	67,151
Employee Meals	9,516
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,780
Employee Benefits	4,217
Union Pension Expense	15,321
Christmas Expense	1,991
401k Contribution	1,554
TOTAL (agree to Schedule V, line 22, col.8)	$ 288,416

* Attach copy of IMRF notifications

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	11,152
Health Care Worker Background Check	750
(Indicate # of checks performed 75)	
Licenses/Permits & Fees	2,043
Dues and Subscriptions	6,138
Allocation - Staycare	403
Yellow page ads	4,781
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(4,781)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,886

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,672
allocation - Staycare	451
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,123

**See instructions.

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HC # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	n/a		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ZIKAINIM INC. D/B/A/ ALL AMERICAN NURSING HOME # 0026294 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **yes**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **IL Council - 6444**

(3) Did the nursing home make political contributions or payments to a politica action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,857** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES **x** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
All-American Nursing Home

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **79,056**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **n/a**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **9,516** Has any meal income been offset against related costs? **n/a** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **none**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **no**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw